District of Columbia State Innovation Model
Community Linkages Work Group: Meeting Summary

December 16, 2015
1:00 p.m.-2:30 p.m.

1) **Participants Present**: Laura Zeilinger; Dena Hasan; Caroline Deneszczuk; Theresa Silla; Vivi Smith; Djinge Lindsay; Peter Tuths; Lisa Fitzpatrick; Jessica Li; Carmen Hernandez; Jasmine Shih; Victor Freeman; DaShawn Groves; Joe Weissfeld; Shelly Ten Napel; Erick Vicks; Melissa McCarthy; Tamara Quillory; Molly Salpeter; Christy Repress; Victor Freeman; Pauletta Sheffield; Tim McNeil
   a) Unable to Identify Attendees: Alyssa, Molly and Mariam

TOPIC	DISCUSSION
Agenda and meeting goals	• Goals ➢ How can Health Homes and social service organizations work together to serve the chronic disease and homeless populations ? ➢ What are the Medicaid authorities and funds that can be used for social services? ➢ What are the business model options?
Health Home 2 Presentation	• *Current DC Landscape*: Minimal support, Individuals making ED visits that could be treated in other facilities or doctor's offices, The largest social need that is a barrier to health is housing • *Envisioned Future Landscape*: Needs assessment to determine health and social needs of the individual, Environment analysis to find gaps in medical and social services, Build health entity

	that links all needs and individual preferences together • *Health Homes:* ACA , Medicaid-Only initiative, Focused on integrates care, Accessible for FFS and MCO • *Eligibility:* 2 chronic conditions or one chronic condition and at risk for another, "At risk" is loosely defined, Must be eligible for Medicaid (this will exclude undocumented immigrants) • *Required Services:* Care management, care coordination, transitional care services and follow-up, patient and family support, referrals to community and social services • *Financing:* This program will have a 90/10 Medicaid match
<u>Open Forum</u> 1. What are the opportunity to address gaps in social services and medical assistance? 2. What are the federal requirements and parameters we are operating within?	• Defining the target population ➢ HH2 will use ICD-10 diagnostic codes to determine chronic condition status ➢ Homeless will be defined as how DC defined "permanent supportive housing" (PSH) – PSH has 2 types of qualifications: The formerly homeless and Housing instability or currently homeless ❖ Utilizing existing technology and data will inform who this population is and where to find these individuals ❖ Would current HH1 enrollees be eligible for HH2? (i) They can only be in one but they can choose (ii) HH1 is opt-in (iii) It is unclear if HH2 will also be voluntary or automatic enrollment. ➢ What about those in housing support that are not PSH? ❖ There is opportunity in Health Homes to support these individuals. However, using the PSH definition was a good start and HH2 activities can be easily crosswalked to PSH activities.
<u>Health Homes and</u>	• *Outreach:* A person is identify and matched to their needs but the housing agency does not have

Social Services Crosswalk 1. What can States now bill towards Medicaid? 2. As professionals working in low-income and homeless housing, what services are needed the most?	an outreach person (a navigator) to assist with finding documentation, applications, etc. • *Medication management:* PSH are not medical providers and do not always have the staff to address medical needs. The team based approach of the Heath Home could address this need • *Families in PSH around trauma and domestic violence:* Beneficial HH service would be assistance with parenting and keep families together, leverage parenting support and conflict resolution • *Care coordination:* Outreach and coordination are time consuming; particularly for customers/patients that do not have paperwork. Beneficiaries visit several hospitals or facilities for medical care and their medical record do not follow them. Facilities then treat and diagnose potentially chronic conditions as episodic. Coordination and primary care are needed to address the root of their health problems; that cannot be done in an ED. • Under Health Homes are social services not billable? ➢ These are new services to Medicaid but have been billable as social services using different funding streams in the past. ➢ Unless you are a BH provider, social service organization don't bill for case management for these services. • Can acute care facilities bill for social services and coordination services? ➢ Not at this time. ➢ It would be the role of the Health Home to provide coordination after a hospital visit and reach out to the discharge team. ➢ Hospitals are incentivized to reduce readmissions or incur a penalty but that is only monitored for Medicare recipients. – Although duals will be eligible in HH2, as in HH1, they may not be the majority. ➢ A questions for the Care Delivery work group would be, how do we incentivize hospitals to participate/assist in coordination? ➢ HIE work group should consider the technologic support needed for hospitals to communicate with Health Homes.

	• Defining the Health Home Services ➢ As DC develops the SPA, included services and how those services are delivered and operationalized are very important. For example, Medicaid has several requirements in order to get reimbursed for care coordination; such as, the services provided must be reflected in the care plan. It must be clear what is billable to Health Homes and what is not. ➢ Additionally, client outreach such as finding homeless individuals is time consuming and costly; many organizations cannot afford to do that. Gathering and requesting documentation is also time consuming and costly. ➢ Health Homes is an opportunity to operationalize these workflows in a way that makes sense for the patient and providers.
Outcomes 1. What are the desired outcomes? 2. What are the metrics of measurement?	• HH has 8 process and 3 utilization measure that all need to report on. Quality SIM team want to collected additional information. The SPA will ask for additional measure if available but its not required
Billing Services and Payment Structure	• DHCF is still considering the payment options but are looking for an alternative payment structure. Options include per member per month (PMPM), incentive payment structures and pay for performance. A capitated payment model could leave providers with the most flexibility. As most beneficiaries are anticipated to be FFS, the medical billing will remain FFS but the care coordination and case managed services could be a capitated PMPM • Payment and Partnership Options ➢ DHS pays for non-Medicaid activities (rent, utilities, etc.) ➢ DHCF – allowed/billable Medicaid services AND social services, services plans, coordination of housing, etc. ➢ *Option 1:* All funds going directly to provider through DHS and DHCF funding streams.

	PSH can provide all social and medical service and become a health home. One entity providers all health and social services. This may mean organizations hiring staff they have not before in order to increase the capacity. ➢ Option 2: DHS and DHCF funding remain the same. HH2 provider (medical) would be responsible for contracting with PSH and outreach to do social service activities. Under this model a Health Home can have more than one contractor. It is unclear at this time if DHCF and DHS will provide guidance on how to reimburse downstream entities. ➢ Options are not mutually exclusive. Different Health Homes can utilize different models of delivery and contracting.
Timeline and Milestones	• The planning timeline building in discussion for best practices. • Please send all questions for January 12 meeting to Dena Hasan • The Care Delivery Work Group will address coding and billing in the future.
2) Homework: HH2 Providers and PSH/Outreach Provider Communication	• Next meeting: February 17th meeting • Health information exchange patient profile. ➢ What is the information that needs to be shared? ➢ What is the infrastructure needed to share information? ➢ Where is data stored? What is the current information storage landscape?
3) Wrap-up and Next Steps	• January 12th meeting – Care Delivery Work Group on Social Services and Health Homes • February 17th meeting – Community Linkages Work Group